Conclusions: Cardiometabolic dysfunction is related to knee OA prevalence and persists within subgroups defined by obesity status and gender. A sex dimorphism in the direction and magnitude of cardiometabolic risk factors with respect to knee OA was described including HOMA-IR being associated with OA prevalence among men while leptin levels were most important among women.

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PRODUCTIVITY COSTS AND MEDICAL COSTS AMONG WORKING PATIENTS WITH KNEE OSTEOARTHRITIS

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Purpose: Osteoarthritis (OA) accounts for the majority of the economic burden of arthritis, estimated at 1 to 2.5% of the gross national product in western countries. Productivity costs and medical costs are the main contributors in this economic burden.
Productivity costs are influenced by several patient-, health- and work characteristics. Body mass index (BMI), musculoskeletal complaints and symptom severity are known for their association with productivity loss. Physical work related factors like lifting heavy loads and psychosocial work related factors like low job autonomy, high job demands and emotionally demanding work are also associated with productivity loss.
Although the knee joint is the most affected joint by OA, research on economic implications focussed merely on OA in general. The main goal of this study was to identify and quantify productivity costs and medical costs in knee OA patients participating in the Dutch labour force. Furthermore, we wanted to evaluate associations between productivity loss and relevant patient-, health- and work characteristics.
Methods: Consecutive knee OA patients consulting an orthopaedic surgeon were included. Inclusion criteria were: Kellgren and Lawrence grade I-III, visual analogue scale (VAS) for pain ≥ 2, age 18–65, conservative treatment ≥ 6 months and participation in the Dutch labour force at time of inclusion.
Productivity loss and absence from work are measured by the Productivity and Disease Questionnaire (PRODISQ). Reduced productivity while being present at work is measured by a quality and quantity scale from 0–10 included in the PRODISQ, in which 10 indicates normal quality or quantity.
Health care consumption was obtained through questionnaires and valued according to Dutch guideline prices and Dutch Health Care Insurance Board tariffs. Regression analyses were used to explore associations between productivity loss and relevant patient-, health- and work characteristics.
Results: In total, 117 knee OA patients were included with a mean age of 53.2 (range 18–65) and a mean BMI of 28.8 (SD 5.1). The mean quantity score was 8.6 (SD 2.3) and the mean quality score was 9.3 (SD 1.6). Productivity loss due to knee complaints (reduced quantity or quality) was reported by 47 subjects (40%) and absence from work by 23 (20%) subjects. Mean productivity loss while being present at work was 14% and patients were 1.5 hours absent from work per week. Housekeeping was compensated by relatives for 1.4 hours per week.
On average, the physical therapist was visited 1.37 times per month; the orthopaedic surgeon and the general physician were visited 0.42 and 0.28 times respectively. Bandages, compresses and braces were the mobility aids used most. Acetaminophen and non-steroidal anti-inflammatory drugs were the drugs used most, with an average of 14.9 and 11.7 tablets per month respectively.
The total monthly costs per symptomatic knee OA patients participating in the labour force are € 830.73. Productivity costs were € 721.80 and medical costs were € 108.93. Productivity costs while being present at work account for 54% of the total costs.
A higher VAS pain during activity and performing physical hard work showed significant associations with productivity loss due to lower quantity of work in the multivariate analyses. A higher VAS pain during activity and a poor socio-emotional work environment were significantly associated with productivity loss due to lower quality at work. Performing physical hard work was significantly associated with absence from work.
Conclusions: Total productivity costs and medical costs of conservatively treated symptomatic knee OA patients in the Dutch labour force are € 830.73 per month. Productivity costs account for 87% of these costs. A higher VAS pain during activity, poor socio-emotional work environment and performing physical hard work were significantly associated with productivity loss due to knee complaints.

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EPIDEMIOLOGICAL ASPECTS OF OSTEOARTHRITIS (OA) IN VENEZUELA: A FREQUENCY STUDY

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Purpose: The aim of the present study is to investigate epidemiological aspects of Osteoarthritis (OA) in Venezuela.
Methods: A multi-center study was conducted in 13 different states from Venezuela that included 1202 patients evaluated at rheumatology outpatient clinics with defined ACR criteria of Osteoarthritis (OA). Epidemiologic aspects were collected using standardized questionnaire between July 1st and September 30th 2010 time period.
Results: 1202 patients met OA criteria for this study. The mean age of patients was 61.7 year-old. There was a 3.4:1 female/male ratio. Mean Body Mass Index (BMI) was 29.2. Overweight (BMI > 25) was seen in 83.4% while obesity (BMI > 30) in 43.1%. Approximately 89% of the patients had primary OA and the time of consultation with diagnosis made within 4 years. Specific OA joint involvement: only knee OA was seen in 342 patients (28.5%); only hands OA in 138 patients (11.5%); hands and knee OA seen in 198 patients (16.5%); axial involvement (cervical and lumbar spine) was seen, together in 82 patients (6.8%); and knee joint involvement with any other joint in 900 patients (74.9%). Radiographic severity of OA on the basis of the Kellgren-Lawrence grading scale (0–4) showed that 84.7% of patients had Kellgren-Lawrence grade 2 (35.4%) and 3 (49.3%). Treatments options for OA included: only NSAIDs (4.6%); NSAID in combination with any other drug (80%); only glucosamine sulphate+chondroitin (55%); glucosamine sulphate + chondroitin +NSAIDs (18.2%); and glucosamine sulphate +chondroitin + others (71%). Comorbidities associated with OA: none seen in 169 patients (14%); only hypertension seen in 151 patients (12%); hypertension with all others in 478 patients (39.8%); only obesity in 117 patients (9.7%); only diabetes seen in 32 patients (2.7%) and diabetes with all others131 patients (10.9%)
Conclusions: This is the first Venezuelan study to evaluate the frequency of OA in rheumatology outpatient setting. This study showed, as well as Latino American results, strong correlation of OA with age greater rate among women than men of the same age. In agreement with other epidemiological studies BMI correlated with frequency of OA. Knees and hands were the most frequently specific joints involved in OA. Treatment of OA between 13 states of Venezuela, showed a diverse spectrum ranging from a combination of analgesic with NSAID to chondroprotection and viscosupplementation. Hypertension, obesity and diabetes were the three most common comorbid conditions more frequently found in our patients. Our epidemiological findings are in agreement with other epidemiological studies and provide a better understanding of the factors contributing to the development of OA in Venezuela and the Latin American population.

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ARTHRITIS AND DIABETES MELLITUS ASSOCIATED WITH MOBILITY IMPAIRMENT: A POPULATION-BASED STUDY

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Purpose: Studies have found that arthritis is associated with an increased risk of disability. However, with the increased prevalence of co-morbid chronic health problems among adults, more research is needed to determine the impact of having arthritis and other co-morbid chronic disorders.
Methods: Data from the 2003–2004 National Health and Nutrition Examination Survey (NHANES) (N = 5,000) were used to assess the possible association of having arthritis and diabetes mellitus with the need of special equipment to walk. The Survey obtained self-report data from persons with arthritis and diabetes on health problems, including the need of special equipment to walk and other measures of